
Overview

PURPOSE

The purpose of the 2002 Houston Area HIV/AIDS Comprehensive Needs Assessment, which is conducted every three years, is to provide accurate and reliable information about the level of use, perception of need, experience of barriers, and analysis of gaps in services to those affected with HIV/AIDS. This information is used by community-based planning bodies to select priorities and recommend allocations of federal and other funds granted to communities to assure a comprehensive continuum of care.

REGION

This Needs Assessment is conducted for the Houston Eligible Metropolitan Area (EMA) and the Houston Health Services Delivery Area (HSDA) designated by the Texas Department of Health (TDH). The EMA is designated by the Health Resources and Services Administration (HRSA), a division of the US Department of Health and Human Services, to receive Ryan White CARE Act funds to provide services to People Living with HIV or AIDS (PLWH/A). The Houston EMA is a six-county area in southeast Texas that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller counties. The Houston HSDA consists of these same six counties and four others—Austin, Colorado, Walker and Wharton. The land area of the combined EMA/HSDA is 9,415 square miles and the 2000 Census showed the population to be slightly more than 4.3 million.

The Houston EMA receives Ryan White Title I funding, which provides emergency relief to metropolitan areas that are disproportionately affected by HIV/AIDS. This funding is awarded to the Harris County Judge's Office and administered by the HIV Services Division of the Harris County Public Health and Environmental Services Department. As the administrative agency for these Title I funds, \$19.3 million in fiscal year 2002, HIV Services subcontracts with more than 30 agencies to provide health and support services to PLWH/A. HIV Services relies on the Ryan White Planning Council, a volunteer collaboration comprised of people affected by HIV, service providers and community leaders, to establish service definitions, set priorities and allocations and to direct long-range planning for Title I funds.

The Houston HSDA is the area designated by HRSA to receive Ryan White Title II and TDH State Services funding, which is intended to improve the quality, availability and organization of health care and support services for PLWH/A, with an emphasis on rural populations. In Texas, Title II and TDH State Services funding is channeled through the Texas Department of Health to the Houston Regional HIV/AIDS Resource Group, Inc. The Resource Group is also the administrative agency for several other funding sources that provide HIV/AIDS services in the area, including Ryan White Title III and IV and some of the funds from Housing Opportunities for Persons with AIDS (HOPWA). The planning body for the HSDA is the State of Texas Assembly Group East (STAGE).

The City of Houston administers Centers for Disease Control (CDC) HIV prevention funds as well as the majority of those from HOPWA.

HOUSTON AREA 2002 EPIDEMIOLOGICAL PROFILE

INTRODUCTION

Numbers, numbers, and more numbers. Numbers are very important to HIV community planning – we need to know the number of people infected with HIV, the number of people living with HIV, the number of dollars coming into the community, the number of providers offering HIV services, and on and on and on. This document is an attempt to present one valuable set of numbers – epidemiological (or epi) data – in a non-technical, user-friendly format.

According to the *Dictionary of Epidemiology*, “epidemiology is the study of the distribution and determinants of health-related states or events in specified populations and the application of this study to the control of health problems.”¹ For HIV community planners, that means looking at who is at risk for or living with HIV, what puts them at risk for infection or declining health, and what can be done to stop new infections and improve health. This epidemiological profile is a description of the status of the HIV epidemic in the Houston area. In order to have as complete a picture as possible, this document includes not only HIV/AIDS data, but also general social and economic information that affect HIV planning. Many types of data from many different sources (e.g., U.S. Census data, data from the State’s HIV/AIDS Reporting System) are included. There was a comprehensive scouring of the Internet, libraries, and agency-specific databases, but the information included here still is not exhaustive. It is simply the information that was available at the time.

The epidemiological profile is one part of a larger effort within the Houston area community – a comprehensive needs assessment. The other parts of the needs assessment are a survey of client needs, a survey of provider capacity, and an analysis of service gaps and barriers. Together with the epi profile, this information will be incorporated into the HIV community planning process and used to inform such essential decisions as setting service priorities and allocating funds.

SOCIODEMOGRAPHIC PROFILE OF THE HOUSTON AREA

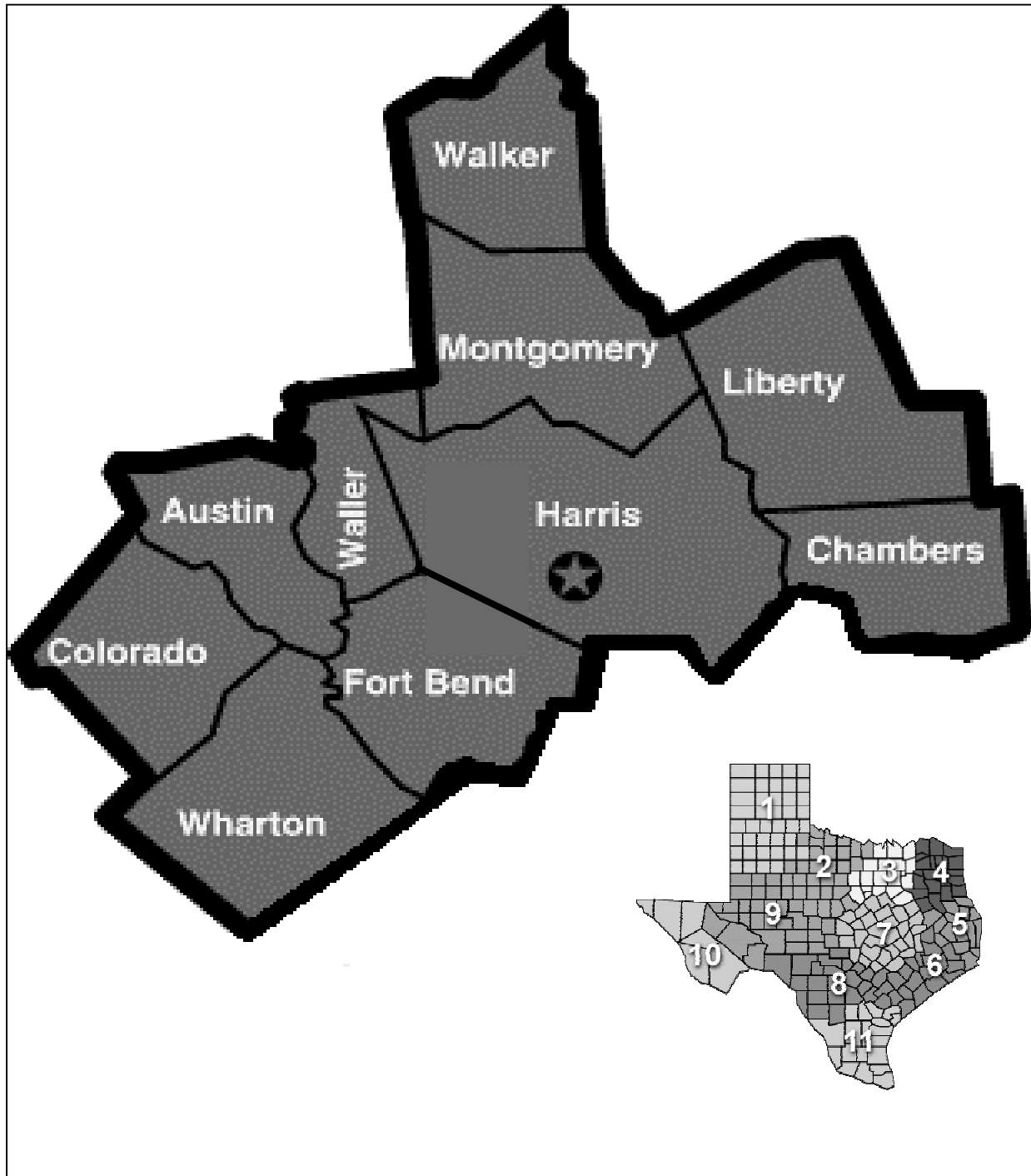
In order to get a better understanding of the impact of HIV, it is important to place it in the context of a general description of the area. The Houston area referred to in this document covers 9,415 square miles of Southeast Texas stretching across 10 counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. A map follows on the next page. The area makes up 3.5% of the State of Texas, is about the size of the State of New Hampshire, and is larger than seven of the other States. It lies within the gulf prairies region, an expanse of flat land that receives about 50 inches of rain per year. The climate is considered moderate, with temperatures generally ranging from 32 to 90 degrees throughout the year, but many residents would disagree as it can reach 90 degrees more than a quarter of the year!

There are two major geographic distinctions that HIV funding sources use in community planning in the area. Under the Ryan White CARE Act, the Health Resources and

¹ Last, JM, ed. *Dictionary of Epidemiology*, 2nd ed. New York: Oxford University Press; 1998:42.

Services Administration (HRSA) uses the Eligible Metropolitan Area (EMA) for HIV funding under Title I and the HIV Services Delivery Area (HSDA) for funding under Title II. The EMA is composed of six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller. The HSDA is composed of these six plus Austin, Colorado, Walker, and Wharton Counties.

Figure EPI-1: MAP OF EMA/HSDA



Transportation

Given the size and climate of the area, transportation is a significant consideration for HIV planning. Houston is the only city in the area served by an urban public transit system. In 1999, Houston METRO vehicles logged more than 59 million miles and served over 99 million passengers. There are 1,572 buses in the METRO fleet that cover 130 bus routes with 15 transfer centers. Twenty-seven of these routes are "Park and Ride," where passengers from outside the city limits can drive to the site and then ride the bus into the city. A 7.5-mile rail line is scheduled to be operational in 2004. METROLift offers transportation to people with disabilities, but hours of operation are limited.

Colorado County is the only county in the area with a rural public transportation operator. This agency had an average of 20 vehicles in 1999 logging almost 76,000 one-way trips and 530,000 vehicle miles. There also are private, non-profit agencies that provide services to the elderly and people with disabilities in the area. According to the Texas Department of Transportation, less than a dozen such agencies were headquartered in this area in 1999. On average, there were a total of 151 vehicles in operation, logging over 260,000 one-way trips and over 5 million vehicle miles. The scope of service for most, in terms of geographic area and populations served, is very limited.

Population

Every ten years, the government of the United States conducts a census, or counts its people. The estimated population of the area for 2000 was 4,324,572, which is about 21% of the Texas population (20,851,820) and larger than the population in 26 states. Harris County is the largest of the ten counties in terms of square miles (1,729) and population (3,400,578). Each of the counties saw a growth in population since the last census in 1990. The percent change in population ranged from 3.1% in Wharton County to 61.2% in Montgomery County. The average percent change across all counties was 29.6%. Along with Montgomery County, the other counties bordering Harris County also saw significant growth: Chambers had a 29.6% change, Fort Bend County 57.2%, Liberty County 33.1%, and Waller County 39.7%. Harris County itself showed a 20.7% change in population (similar to that for the State, 22.8%). Table 1 lists the geographic size, population, and population density of each county according to the 2000 Census.

Table EPI-1: POPULATION, SQUARE MILES, & POPULATION DENSITY, BY GEOGRAPHIC AREA

County	Population	Square miles	Population Density
Austin	23,590	653	36
Chambers	26,031	599	43
Colorado	20,390	963	21
Fort Bend	354,452	875	405
Harris	3,400,578	1,729	1,966
Liberty	70,154	1,160	60
Montgomery	293,768	1,044	281
Walker	61,758	788	78
Waller	32,663	514	64
Wharton	41,188	1,090	38
EMA	4,177,646	5,921	706
HSDA	4,324,572	9,415	459
TOTAL	4,324,572	9,415	459

The median age for the entire area is 34.13 years, meaning half of the population is older and half is younger. This is slightly over the median age of 32.3 years for the entire state. The median ages for the individual counties fell within the 30 to 40 year age range. Fort Bend County has the largest percentage of people under 18 years old (32%) and the smallest over 65 years old (18.6). Walker County had the smallest percentage of people under 18 (18%) and Colorado County had the largest over 65 (18.6%).

Males and females are distributed almost equally in each county, except Walker County, where the split is 39.8% female vs. 60.2% male.

The population in all of the counties is predominantly Anglo, ranging from 57.0% in Fort Bend County to 88.3% in Montgomery County. African Americans are the largest minority group in each county, ranging from 3.5% in Montgomery County to 29.2% in Waller. The largest Asian/Pacific Islander (API) population, 11.2%, resides in Fort Bend County. The American Indian/Alaskan Native population consistently is in the 0.3% to 0.5% range across all counties. The "Other" category includes those who designated themselves as multiracial, with the highest percentage (3.0%) in Harris County. The Hispanic population is considered separately because this profile follows Federal guidelines and treats Hispanic as an *ethnic* categorization, rather than as a race. This means that the Hispanic category is not mutually exclusive of the racial categories; in other words, a person could be both Hispanic and White or Hispanic and American Indian. With that in mind, the average percentage of Hispanics across all counties is 18.9%. Harris County has the largest proportion of Hispanics at 32.9%, with the majority (80.1%) of Mexican origin. Chambers County has the lowest proportion of Hispanics (10.8%). Overall, Harris County and neighboring Fort Bend County are the most racially/ethnically diverse counties in the area. Table 2 lists the gender distribution and racial/ethnic composition for each county as a percentage of the total population.

Table EPI-2: GENDER DISTRIBUTION AND RACIAL/ETHNIC COMPOSITION, BY COUNTY

County	Gender (%)		Race/ethnicity (%)					
	F	M	Hispanic	African-American	Anglo	API	American Indian	Other
Austin	50.9	49.1	16.1	10.6	80.2	0.3	0.3	8.6
Chambers	49.8	50.2	10.8	9.8	81.9	0.7	0.5	7.2
Colorado	51.2	48.8	19.7	14.8	72.8	0.2	0.4	11.8
Fort Bend	50.2	49.8	21.1	19.8	57.0	11.2	0.3	11.7
Harris	50.2	49.8	32.9	18.5	58.7	5.1	0.5	7.4
Liberty	51.1	48.9	10.9	12.8	78.9	0.3	0.5	16.4
Montgomery	50.4	49.6	12.6	3.5	88.3	1.1	0.5	6.7
Walker	39.8	60.2	14.1	23.9	69.1	0.9	0.4	5.8
Waller	50.3	49.7	19.4	29.2	57.8	0.4	0.5	12.1
Wharton	50.8	49.2	31.3	15.0	69.0	0.4	0.4	15.2

Most of the residents in the 10-county area live in Houston, the largest city in Texas and the fourth largest city in the United States (behind New York, Los Angeles and Chicago). Within city limits, the estimated population is 1.8 million, with the gender distribution split down the middle – 50.1% female and 49.9% male. The median age is slightly younger than the surrounding areas (30.9 years). The city also is more racially/ethnically diverse, with 49.3% of Houston’s population Anglo, 25.3% African American, 5.4% Asian/Pacific Islander, 0.4% American Indian, and 16.5% listing another race (with 3.1% multiracial). Over a third of the city’s total population (37.4%) is Hispanic.

Economics

The 2000 U.S. Census also provided us with some economic information. For example, the 1997 estimated median household income for the area ranged from just under \$29,000 to just over \$55,000, with an average of almost \$37,000. This compares favorably to the statewide median of \$34,478. However, the numbers of people living below the poverty level were not insignificant. The percentage of people below poverty ranges from 8.0% in Fort Bend County to 20.9% in Waller County, with an average for all counties of 15.0%. For children, the range is from 10.6% in Fort Bend to 26.9% in Waller, for an average of 20.0%. The statewide rates were 13.3% overall and 19.9% for children. Table 3 presents this information by county and includes additional estimates for 1999 from the Texas Health and Human Services Commission. The percentages for all people and for children increased in all but a few counties: Harris, Walker, and Waller Counties for all people and Harris, Liberty, Walker, and Waller Counties for children. Although numbers were not available for each county, statewide, the majority of those living in poverty in 1997 were female (55.3%) and Hispanic (53.2%).

Table EPI-3: POVERTY ESTIMATES, BY COUNTY

County	1997 Median household income	1997 Persons below poverty (%)	1997 Children below poverty (%)	1999	
				Total (%)	Children (%)
Austin	\$33,945	13.1	17.7	15.9	22.3
Chambers	\$43,345	10.8	16.5	13.9	17.2
Colorado	\$28,966	17.1	23.9	20.1	28.9
Fort Bend	\$55,164	8.0	10.6	10.5	14.3
Harris	\$39,037	15.2	20.9	12.6	20.0
Liberty	\$31,683	17.2	22.9	17.8	22.3
Montgomery	\$46,292	10.3	14.6	11.6	15.4
Walker	\$30,971	19.9	22.5	18.3	20.0
Waller	\$29,832	20.9	26.9	18.9	25.7
Wharton	\$30,531	17.4	23.0	18.5	25.2

The Census Bureau determines poverty by using money income before taxes and comparing it to a set threshold that varies according to family size and is updated annually for inflation. For instance, in 1997 (the year on which these estimates are based), if the income for a family of three was \$12,802, everyone in that family would be considered poor. [Please note: the poverty threshold is *not* the same as the Federal Poverty Guidelines, which are a simplification of the thresholds and are used for such administrative purposes as determining eligibility for certain Federal programs.] These poverty thresholds are used for statistical purposes.

One illustration of this fact is the number of people who do not have health insurance coverage. As a state, Texas ranked first in the U.S. in 1998 according to percent of population uninsured (24.5%) and number 2 according to the size of the uninsured population (4,880,000). In the 10-county area, most counties had about a quarter of their population uninsured, ranging from 19.9% in Austin County to 25.5% in Harris County. Chambers County had the lowest percentage of uninsured children (20.8%) and Harris County had the highest (25.5%). Montgomery County had the lowest percentage of uninsured adults (22.6%) and Waller County had the highest (30.1%). Figures from the Texas Health and Human Services Commission for all counties are included in Table 4. A demographic breakdown of those living without insurance was not available by county. Statewide, the majority was male (53.6%) and Hispanic (48.3%).

Table EPI-4: ESTIMATED PEOPLE WITHOUT INSURANCE, BY COUNTY, 1999

County	All people (%)	% Children (0-18 years old)	%Adults (19-64 years old)
Austin	19.9	22.7	24.4
Chambers	20.3	20.8	23.7
Colorado	20.8	24.0	26.7
Fort Bend	22.7	22.4	24.6
Harris	25.5	25.5	28.1
Liberty	22.4	22.8	26.2
Montgomery	20.1	21.0	22.6
Walker	25.4	22.9	29.5
Waller	25.4	25.1	30.1
Wharton	23.1	25.0	27.5

Another economic indicator is the unemployment rate, which calculates the number of people who are currently and actively seeking work and who are unable to find suitable employment. The 1998 unemployment rate in the 10-county area ranged from 2.2% in Walker County to 6.5% in Liberty County, with an average rate of 4.1%, which was in line with the state rate of 4.0%. There was little variation in the rate for December 2001 in the 10-county area, with both slight rate decreases and increases. This is a somewhat better showing than the state, which saw the unemployment rate increase to 5.1% in the same timeframe. Table 5 presents unemployment rates for each county according to the Texas Health and Human Services Commission.

Table EPI-5: UNEMPLOYMENT RATE, BY COUNTY

County	1998	December 2001
Austin	3.3%	2.7%
Chambers	4.2%	4.2%
Colorado	3.9%	3.2%
Fort Bend	2.9%	3.2%
Harris	4.2%	4.6%
Liberty	6.5%	6.3%
Montgomery	3.4%	3.7%
Walker	2.2%	2.0%
Waller	4.3%	4.0%
Wharton	5.6%	4.8%
Texas	4.0%	5.1%

Health and Health Resources

Because the City of Houston is home to one of the world's largest medical centers, it has a high concentration of hospitals, clinics, health care providers, researchers, and other health care resources. People living in rural areas, however, have difficulty

accessing health services. These areas are simply less likely to have adequate numbers of health care providers.

The U.S. Department of Health and Human Services (DHHS) has given medically underserved status to certain geographic areas or populations having a shortage of personal health services. Eligibility for this designation is based on the following demographics of the entire population as compared to national statistics: population over 65 years, poverty rate, infant mortality rate, and ration of primary care per 1,000 population; eligibility for populations is calculated the same way but based only on a portion of the area's population. These populations must be encountering economic or social barriers to primary care access. In the Houston area, Austin, Chambers, Colorado, Liberty, Walker, Waller, and Wharton Counties are designated as Medically Underserved Areas (MUAs); Fort Bend, Harris, and Montgomery Counties have sub-county MUAs; and Harris County has a population designated as Medically Underserved Populations (MUPs). This population is those living in poverty and the Spanish-speaking and immigrant populations in ten census tracts in Southwest Houston.

DHHS also recognizes geographic areas and populations as having an acute shortage of health care personnel in three professions: primary medical care, dentistry, and mental health. Areas are designated as Health Professional Shortage Areas (HPSAs) based on the population to physician ratio and the reasonable accessibility of physicians. Austin, Chambers, and Waller Counties are designated as HPSAs for primary medical care and Harris County has a partial HPSA designation for over 50 census tracts. Liberty County is an HPSA for dentists and Austin, Colorado, Fort Bend, Liberty, Montgomery, Walker, Waller, and Wharton Counties are HPSAs for mental health professionals.

One final characteristic of interest is overall health status of the area. The University of Texas-Houston's School of Public Health and St. Luke's Episcopal Health Charities released 1999 county-level "health report cards" for the Episcopal Diocese of Texas, an area that includes the 10 counties in the Houston area.² The report cards score the counties on a number of health and social indicators, including number of low weight births; reported cases of TB, AIDS, and syphilis; and number of premature deaths. Four of the counties – Colorado, Walker, Waller, and Wharton – ranked in the bottom half on health indicators. Only Fort Bend, Chambers, and Montgomery Counties ranked in the top quarter.

IMPACT OF HIV/AIDS IN THE POPULATION

Both HIV and AIDS data are used in this profile. There are certain caveats to remember about each of these. In Texas, AIDS has been a reportable condition since 1983 and HIV only since 1999. This means that health care providers are required to report known HIV/AIDS cases to local health departments. HIV numbers, however, include only those newly diagnosed after January 1, 1999 through confidential testing (vs. anonymous testing). AIDS data reflect a fairly complete picture of the end stages of the epidemic,

² St. Luke's Episcopal Charities website: http://www.slehc.org/chis_report.htm

because people with AIDS are sick enough to access health care and be reported to the local health department. HIV data reflects test-seeking behavior of those who either consider themselves at risk for infection or come in contact with some routine testing protocol, such as pregnant females or sexually transmitted infection (STI) clinic patients. In addition, only tests conducted after 1/1/99 are reportable. Therefore, AIDS data are much more complete and reliable. However, since an AIDS diagnosis can occur many years after an initial infection of HIV, AIDS data tells a story that could be 10 to 15 years old. HIV data, on the other hand, may more accurately describe current patterns of transmission. In the end, both HIV and AIDS data are needed to get the most comprehensive picture of the epidemic.

Reported AIDS Cases

Cumulative Cases

Cumulative case reports show the total number of people ever reported to have an AIDS diagnosis, regardless of whether these people are still living. From the beginning of the epidemic, Texas has seen some of the highest number of reported AIDS cases, with almost 57,000 through September 2001. Tables 6 through 8 show the demographic profile of reported cumulative AIDS cases for Texas. The majority is male (88%), Anglo (53%), between 30 and 39 years old (47%), and attributed to unprotected male-to-male sex (59%).

Table EPI-6: CUMULATIVE AIDS CASES, BY AGE GROUP, TEXAS – THROUGH 9/30/01

Age group	Total
13 - 19	386
*20 - 29	11,752
30 - 39	26,265
40 - 49	12,747
50+	4,856
Total	56,006

* Age group 20 – 29 is a combination of youth age 20-24 and adults age 25-29.

Table EPI-7: CUMULATIVE AIDS CASES, BY GENDER/RACE/ETHNICITY, TEXAS – THROUGH 9/30/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	1,828	27,345	29,173
African American	3,541	12,344	15,885
Hispanic	1,081	9,586	10,667
Other/Not specified	31	250	281
Total	6,481	49,525	56,006

Table EPI-8: CUMULATIVE AIDS CASES, BY GENDER/BEHAVIORAL RISK, TEXAS – THROUGH 9/30/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	32,830	32,830
Injection drug use (IDU)	2,318	5,565	7,883
MSM and IDU	0	5,131	5,131
Heterosexual contact	2,774	1,951	4,725
Other/Not specified	1,389	4,048	5,437
Total	6,481	49,525	56,006

Throughout the years, the Houston area typically has accounted for about one-third of AIDS cases in Texas. Through December 2001, the number of cumulative reported cases was 20,086, or 35% of the U.S. total. Following the State pattern, most of these were male (87%), Anglo (51%), between 30 and 39 years old (46%), and attributed to unprotected male-to-male sex (59%). Tables 9 through 11 provide more details.

Table EPI-9: CUMULATIVE AIDS CASES, BY GENDER/AGE GROUP, HOUSTON AREA – THROUGH 12/31/01

Age group	Female	Male	Total
13 - 19	85	73	158
*20 - 29	784	3,333	4,117
*20 - 24	281	717	998
*25 - 29	503	2,616	3,119
30 - 39	1,016	8,199	9,215
40 - 49	506	4,226	4,732
50 - 59	163	1,223	1,386
60 - 69	54	335	389
70+	18	71	89
Total	2,626	17,460	20,086

* Age group 20 – 29 is a combination of youth age 20-24 and adults age 25-29.

Table EPI-10: CUMULATIVE AIDS CASES, BY GENDER/RACE/ETHNICITY, HOUSTON AREA – THROUGH 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	523	9,669	10,192
African American	1,740	5,095	6,835
Hispanic	358	2,623	2,981
Other/Not specified	5	73	78
Total	2,626	17,460	20,086

Table EPI-11: CUMULATIVE AIDS CASES, BY GENDER/BEHAVIORAL RISK, HOUSTON AREA – THROUGH 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	11,925	11,925
Injection drug use (IDU)	872	1,599	2,471
MSM and IDU	0	1,748	1,748
Heterosexual contact	1,375	1,055	2,430
Other/Not specified	379	1,133	1,512
Total	2,626	17,460	20,086

Living AIDS cases

While a profile of cumulative cases help show the road AIDS has taken in a community, the focus of the service delivery system is on the people who are living with HIV/AIDS. According to TDH, through December 31, 2001, there were 24,531 people living with AIDS in Texas. Most of the people with AIDS are male (84%), Anglo (44%) or African American (33%), between the ages of 30 and 39 (48%), and infected through unprotected male-to-male sex (51%). Tables 12 through 14 show the demographic profile of these cases.

Table EPI-12: LIVING AIDS CASES, BY GENDER AND AGE GROUP, TEXAS – THROUGH 12/31/01

Age group	Female	Male	Total
13 - 19	111	123	234
*20 - 29	1,137	3,891	5,028
*20 - 24	395	886	1,281
*25 - 29	742	3,005	3,747
30 - 39	1,608	10,076	11,684
40 - 49	765	4,969	5,734
50 - 59	223	1,267	1,490
60 - 69	54	251	305
70+	16	40	56
Total	3,914	20,617	24,531

* Age group 20 – 29 is a combination of youth age 20-24 and adults age 25-29.

Table EPI-13: LIVING AIDS CASES, BY GENDER/RACE/ETHNICITY, TEXAS – THROUGH 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	1,001	9,701	10,702
African American	2,188	5,946	8,134
Hispanic	700	4,826	5,526
Other/Not specified	25	144	169
Total	3,914	20,617	24,531

Table EPI-14: LIVING AIDS CASES, BY GENDER AND BEHAVIORAL RISK, TEXAS – THROUGH 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	12,559	12,559
Injection drug use (IDU)	1,295	2,624	3,919
MSM and IDU	0	2,134	2,134
Heterosexual contact	1,716	1,157	2,873
Other/Not specified	903	2,143	3,046
Total	3,914	20,617	24,531

In the 10-county Houston area, there were more than 7,600 people reported to be living with AIDS in 2001. Again, the majority of living AIDS cases is male (81%), between 30 and 39 years old (45%), and attributed to unprotected male-to-male sex (50%). In terms of race/ethnicity, however, most living AIDS cases were among African Americans (41% vs. 39% for Anglos). Tables 15 through 17 provide more details.

Table EPI-15: LIVING AIDS CASES, BY GENDER AND AGE GROUP, HOUSTON AREA – THROUGH 12/31/01

Age group	Female	Male	Total
13 - 19	57	39	96
*20 - 29	443	1,139	1,582
*20 - 24	159	275	434
*25 - 29	284	864	1,148
30 - 39	584	2,882	3,466
40 - 49	287	1,568	1,855
50 - 59	88	434	522
60 - 69	18	76	94
70+	3	18	21
Total	1,480	6,156	7,636

* Age group 20 – 29 is a combination of youth age 20-24 and adults age 25-29.

Table EPI-16: LIVING AIDS CASES, BY GENDER AND RACE/ETHNICITY, HOUSTON AREA – THROUGH 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	252	2,763	3,015
African American	991	2,159	3,150
Hispanic	235	1,189	1,424
Other/Not specified	2	45	47
Total	1,480	6,156	7,636

Table EPI-17: LIVING AIDS CASES, BY GENDER/BEHAVIORAL RISK, HOUSTON AREA – THROUGH 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	3,796	3,796
Injection drug use (IDU)	437	639	1,076
MSM and IDU	0	612	612
Heterosexual contact	835	601	1,436
Other/Not specified	208	508	716
Total	1,480	6,156	7,636

Trends in AIDS Diagnoses

The numbers presented above provide an overall picture of AIDS at a particular point in time. By looking at the course of the epidemic over time, the community will get a better understanding of what to expect in the future.

In the Houston area, the number of AIDS cases diagnosed each year has dropped steadily since 1996, falling from 1,687 that year to 431 in 2001. While that is good news overall, communities of color have seen steady increases in their proportion of the total number of cases diagnosed each year. In 1997, African Americans surpassed Anglos for the first time, accounting for 47% of cases; in 2001, that percentage increased to 54%. The Hispanic population has seen less dramatic, but still steady, increases. In 2001, they too surpassed the Anglo community, accounting for 23% of the AIDS cases diagnosed (vs. 22% for Anglos). In terms of behavioral risk, the proportion of AIDS diagnoses attributed to unprotected heterosexual contact has increased, accounting for 27% of the total in 2001. By contrast, the proportion attributed to unprotected male-to-male sex has steadily decreased from a high of 75% at the beginning of the epidemic to a low of 33% in 2001. It also is worthy of note that the proportion of cases with an unknown attributable risk behavior has increased steadily to 27% of cases diagnosed in 2001. These are cases for which not enough information regarding sexual partners is known to fit the stringent CDC definition of heterosexual contact. Based on data gathered by the local health department, however, it is thought that many of these cases among females actually can be attributed to unprotected heterosexual contact. The following three figures show the percentage of AIDS cases diagnosed each year through 2001 and the distribution for age, race/ethnicity, and behavior risk.

Figure EPI-2: AIDS CASES BY YEAR OF DIAGNOSIS, HOUSTON AREA - THROUGH 12/31/01

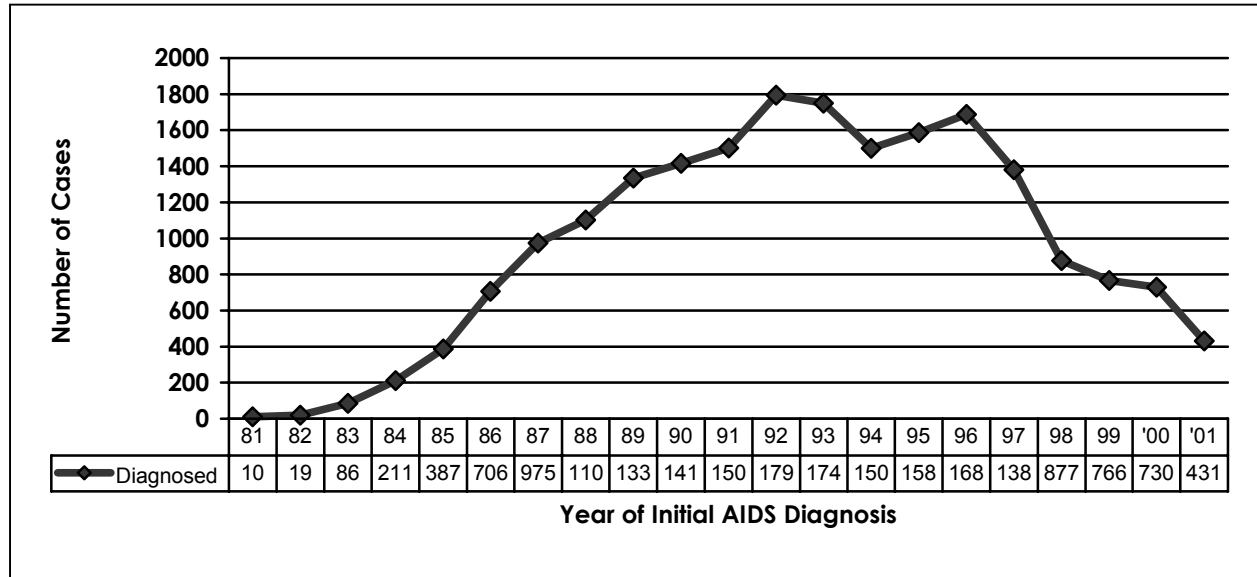


Figure EPI-3: PERCENT OF AIDS DIAGNOSIS BY AGE GROUP, HOUSTON AREA - THROUGH 12/31/01

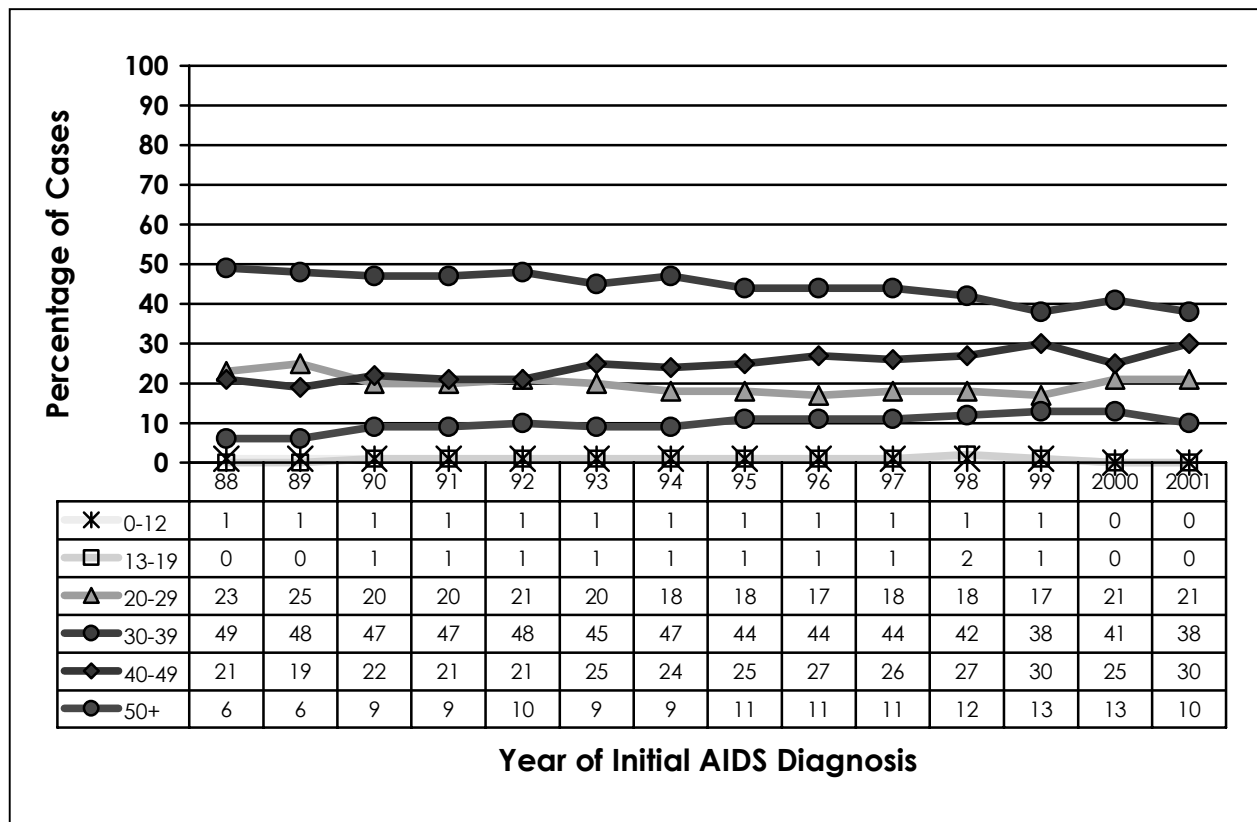


Figure EPI-4: PERCENT OF AIDS DIAGNOSES BY RACE/ETHNICITY AND YEAR OF DIAGNOSIS HOUSTON AREA - THROUGH 12/31/02

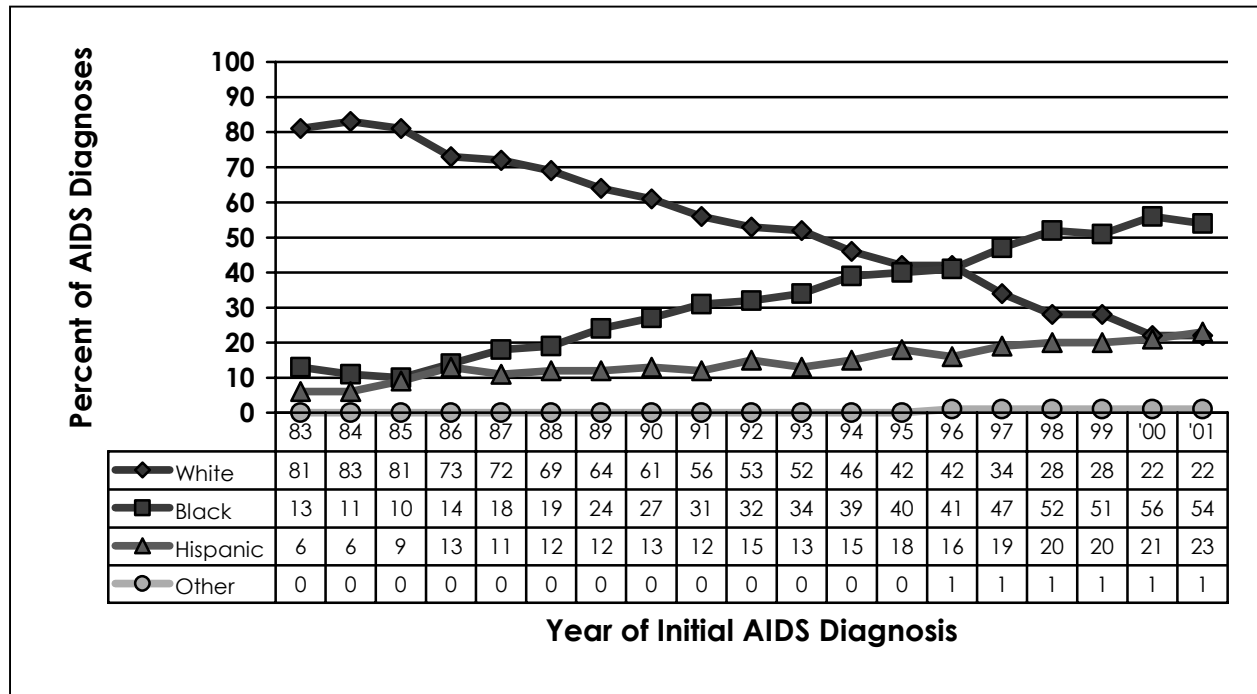
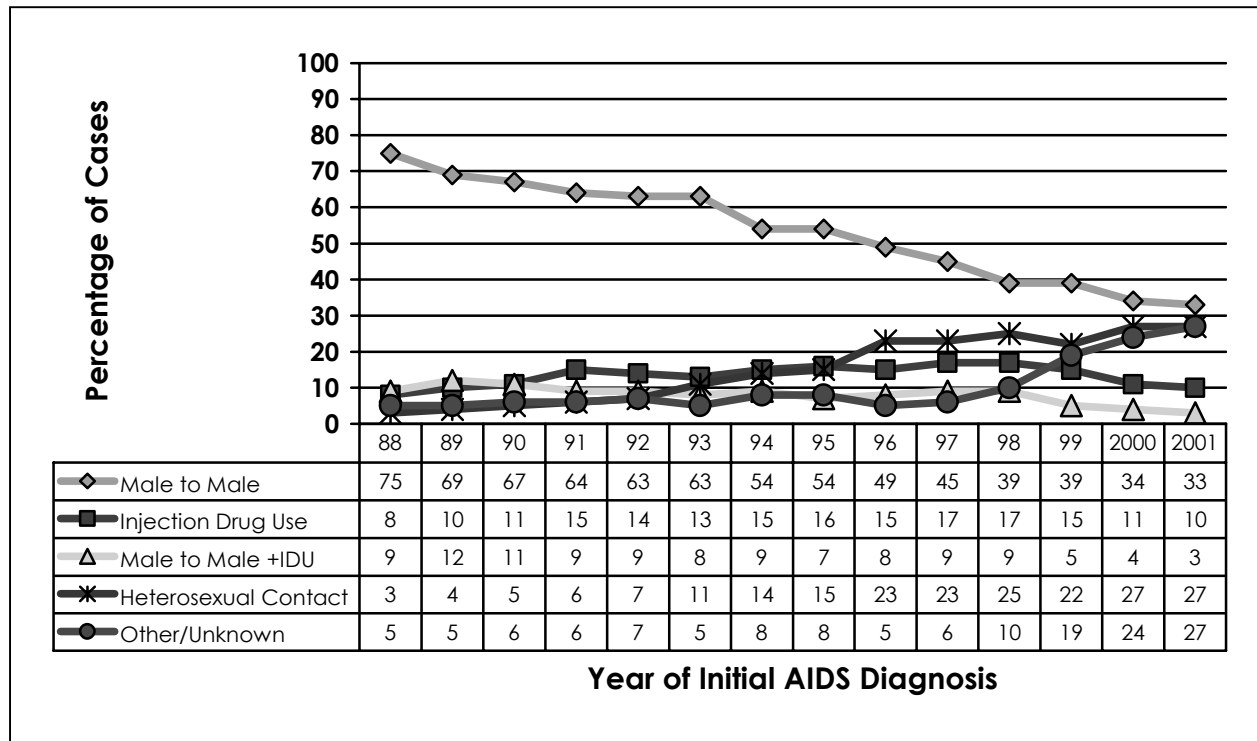


Figure EPI-5: PERCENT OF AIDS DIAGNOSES BY BEHAVIORAL RISK HOUSTON AREA - THROUGH 12/31/01



Reported HIV Cases

As stated earlier, the number of AIDS cases does not tell the whole story. Looking at the number of reported HIV cases gives us a better indication of more recent trends in infection. Remember, these include only the HIV positive tests from confidential testing sites after January 1, 1999 and those with detectable viral load assays after January 2, 2000. They do not necessarily capture those people who tested positive before that date, those who tested positive at anonymous sites, or those who never got tested anywhere, anytime. Because HIV reporting is a relatively new process and the numbers are very similar, we will look at living reported infections and not cumulative infections.

According to TDH, through December 31, 2001, there were over 10,500 reported cases of people living with HIV infection. The demographics of HIV infections look a little different than those of people living with AIDS. Most people living with HIV infection are male (71%). About 39% are between the ages of 30 and 39 and 31% are between the ages of 20 and 29. Just over one third of cases are attributed to unprotected male-to-male sex (36%). Cases attributed to unprotected heterosexual contact and unsafe injection drug use each account for about 16% of the total cases and cases that cannot be attributed to one of the specified behaviors account for 25% of the total. More African Americans (43%) are living with HIV in Texas than any other race/ethnicity. Anglos are next with 36% of the cases, followed by Hispanics with about 20%. Tables 18 through 20 show more details.

Table EPI-18: LIVING HIV INFECTIONS, BY GENDER AND AGE GROUP, TEXAS – THROUGH 12/31/01

Age group	Female	Male	Total
13 - 19	341	140	481
*20 - 29	1,142	2,136	3,278
*20 - 24	581	802	1,383
* 25 - 29	561	1,334	1,895
30 - 39	935	3,184	4,119
40 - 49	457	1,522	1,979
50 - 59	136	387	523
60 - 69	26	78	104
70+	8	15	23
Total	3,045	7,462	10,507

* Age group 20 – 29 is a combination of youth age 20-24 and adults age 25-29.

Table EPI-19: LIVING HIV INFECTIONS, BY GENDER AND RACE/ETHNICITY, TEXAS – THROUGH 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	686	3,074	3,760
African American	1,836	2,714	4,550
Hispanic	503	1,583	2,086
Other/Not specified	20	91	111
Total	3,045	7,462	10,507

Table EPI-20: LIVING HIV INFECTIONS, BY GENDER/BEHAVIORAL RISK, TEXAS – THROUGH 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	3,778	3,778
Injection drug use (IDU)	695	999	1,694
MSM and IDU	0	691	691
Heterosexual contact	1,233	482	1,715
Other/Not specified	1,117	1,512	2,629
Total	3,045	7,462	10,507

Through December 2001, TDH reports just over 3,400 people living with HIV in the Houston area. The profile of people living with HIV differs from that of people living with AIDS. While males still account for the majority of people living with HIV, the difference between the genders is far less dramatic: 64% for males vs. 36% for females. In terms of age, there is an even split between the 20 to 29 and the 30 to 39 groups, each accounting for about 36%. African Americans account for 58% of people living with HIV, more than twice the percentage in the Anglo community (27%). Finally, the number of cases attributed to unprotected sex is almost the same for heterosexual sex as it is for male-to-male sex, at 27% and 33%, respectively. Tables 21 through 23 show more details.

Table EPI-21: LIVING HIV INFECTIONS, BY GENDER AND AGE GROUP, HOUSTON AREA – THROUGH 12/31/01

Age group	Female	Male	Total
13 - 19	124	31	155
*20 - 29	544	702	1,246
*20 - 24	319	296	615
* 25 - 29	225	406	631
30 - 39	341	910	1,251
40 - 49	167	409	576
50 - 59	49	104	153
60 - 69	6	20	26
70+	2	5	7
Total	1,233	2,181	3,414

* Age group 20 – 29 is a combination of youth age 20-24 and adults age 25-29.

Table EPI-22: LIVING HIV INFECTIONS, BY GENDER/RACE/ETHNICITY, HOUSTON AREA – THROUGH 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	164	758	922
African American	929	1,055	1,984
Hispanic	135	355	490
Other/Not specified	5	13	18
Total	1,233	2,181	3,414

Table EPI-23. LIVING HIV INFECTIONS, BY GENDER/BEHAVIORAL RISK, HOUSTON AREA – THROUGH 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	1,139	1,139
Injection drug use (IDU)	224	228	452
MSM and IDU	0	161	161
Heterosexual contact	705	228	933
Other/Not specified	304	425	729
Total	1,233	2,181	3,414

Figure EPI-6: HIV NOT AIDS CASES BY GENDER, HOUSTON AREA – THROUGH 12/31/01

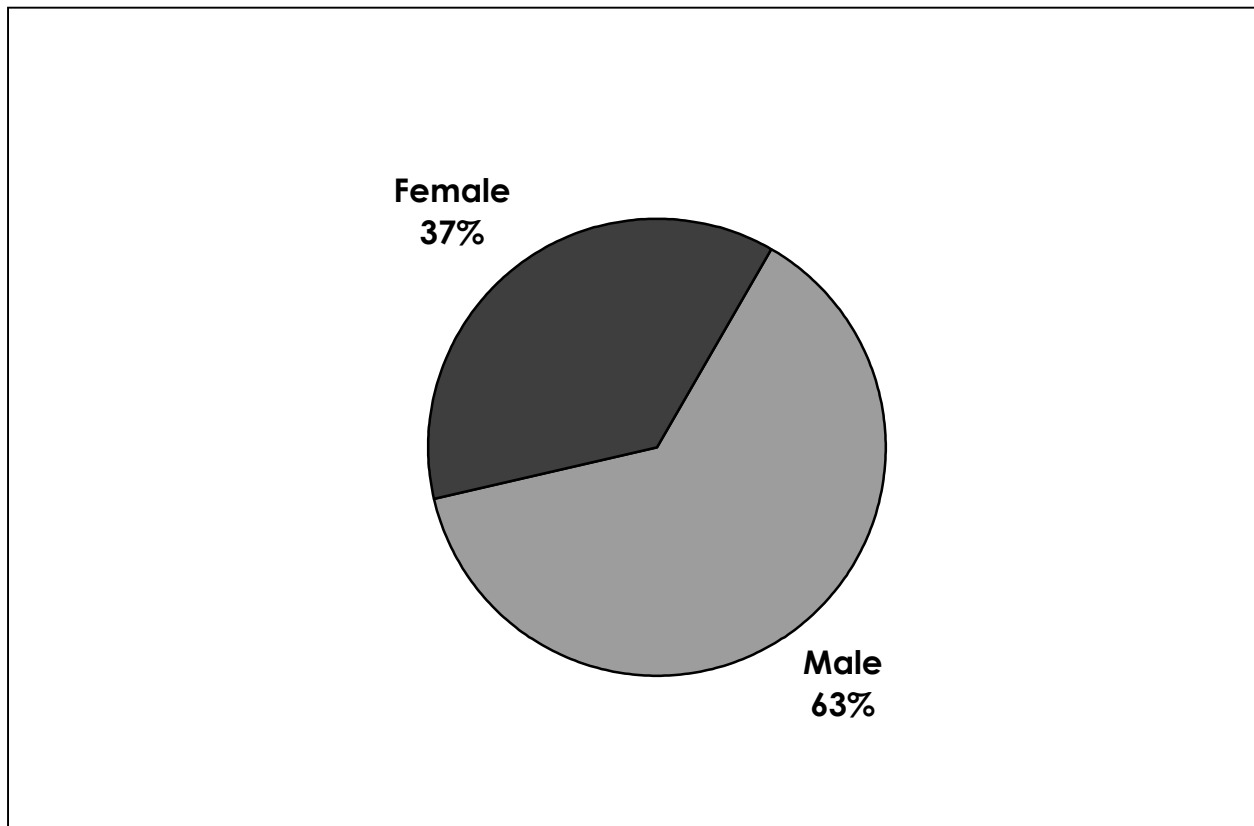


Figure EPI-7: HIV NOT AIDS CASES BY RACE/ETHNICITY, HOUSTON AREA – THROUGH 12/31/01

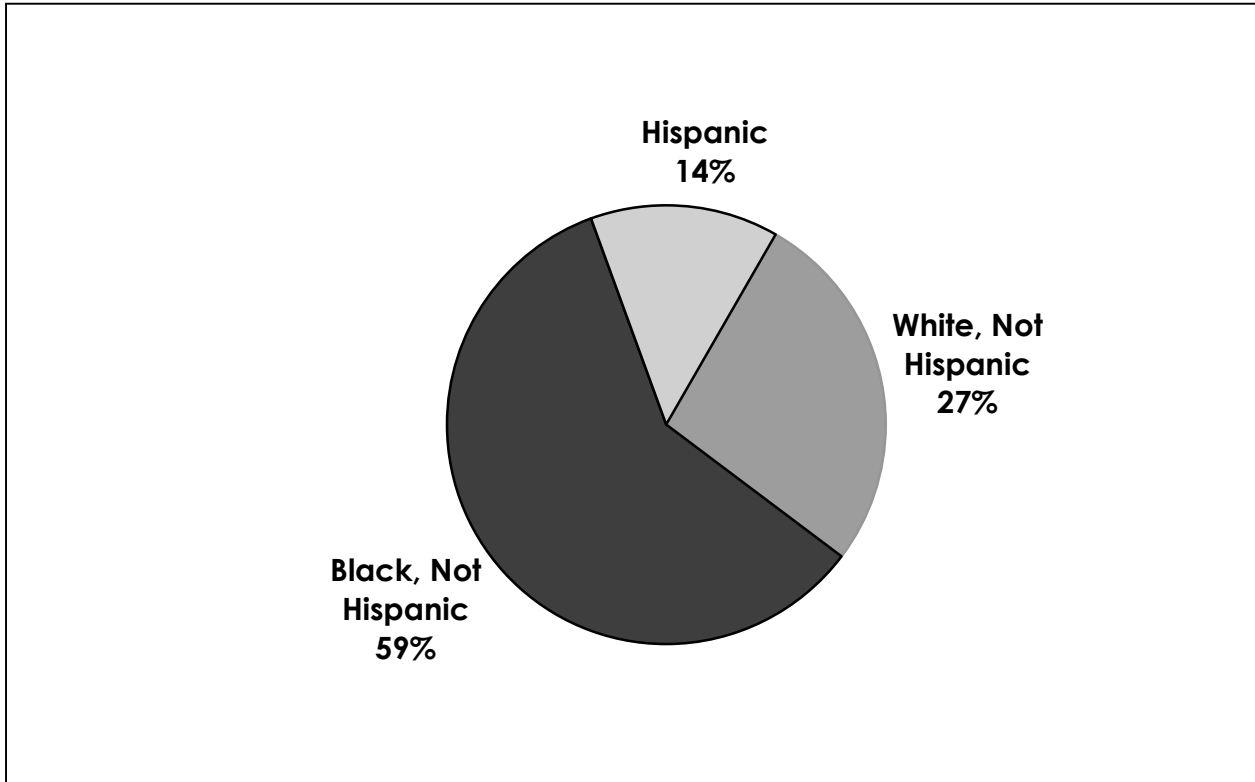
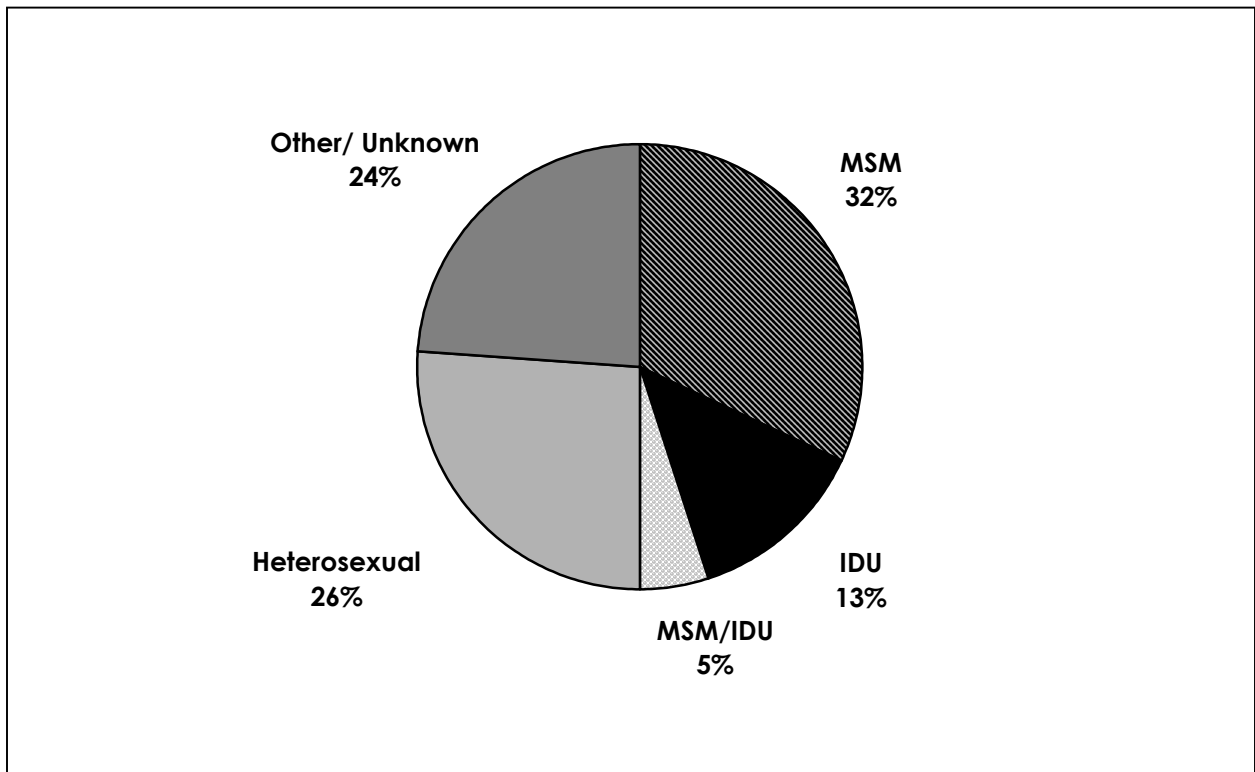
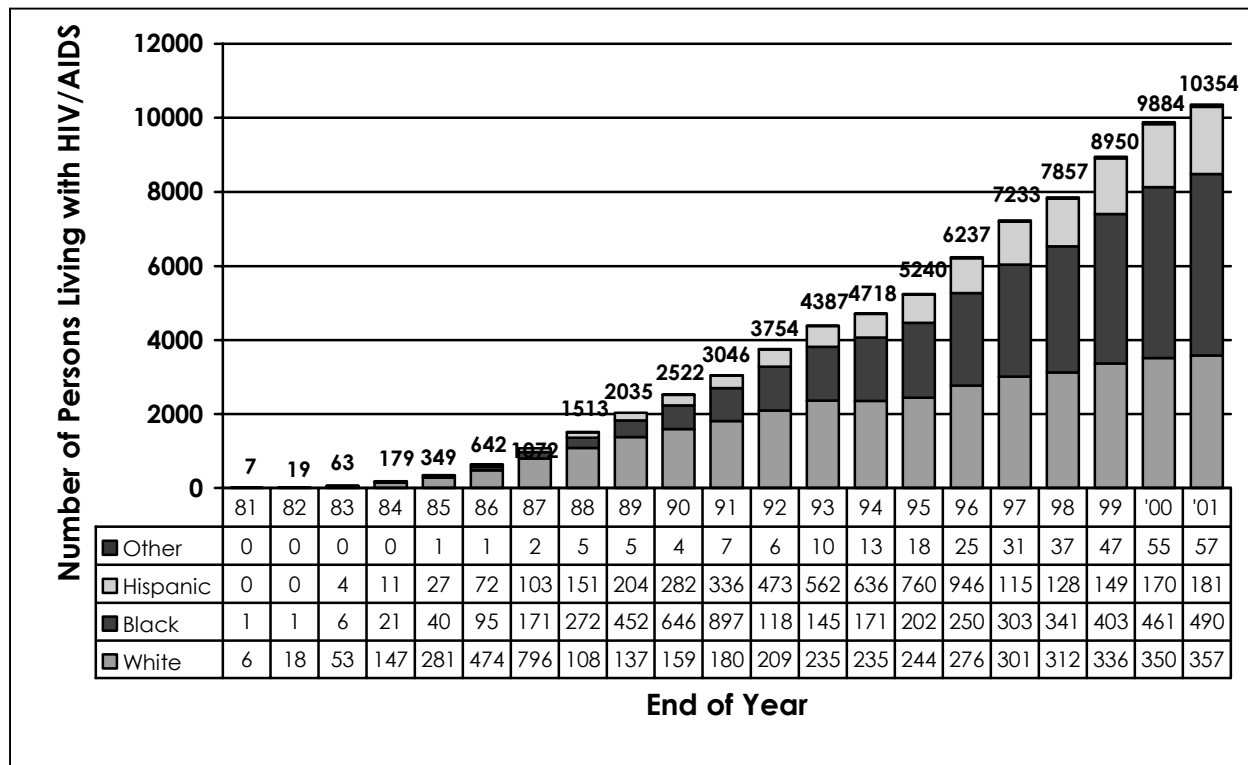


Figure EPI-8: HIV NOT AIDS CASES BY BEHAVIORAL RISK, HOUSTON AREA – THROUGH 12/31/01



The figure below shows the number of people living with both HIV and AIDS over the course of time by race/ethnicity. This illustrates one of the more dramatic shifts in the changing face of HIV.

Figure EPI-9: LIVING WITH HIV/AIDS AT THE END OF EACH YEAR BY RACE/ETHNICITY, HOUSTON AREA – THROUGH 12/31/01



Pediatric HIV/AIDS

One of the bright spots in the fight against HIV is the success in reducing the number of AIDS cases among children aged 0 to 12 years. Table 24 presents the number of children living with HIV/AIDS by race/ethnicity and gender.

Table EPI-24: LIVING PEDIATRIC AIDS CASES & HIV INFECTIONS, HOUSTON AREA – THROUGH 12/31/01

Race/ethnicity	Living with AIDS			Living with HIV		
	Female	Male	Total	Female	Male	Total
Anglo	3	3	6	6	14	20
African American	22	19	41	51	51	102
Hispanic	12	10	22	10	9	19
Other/Not specified	0	0	0	4	4	8
Total	37	32	69	71	78	149

Estimates of HIV Prevalence

When a person becomes ill with full-blown AIDS, typically some contact is made with the medical care profession, and a case report to the HIV/AIDS Surveillance Program of the local health department results. AIDS incidence (number of *new* cases) and prevalence (number of cases at a particular point in time) data are therefore reasonably complete and portray an accurate picture of the AIDS epidemic in an area. With the advent of HAART therapy, a dramatic decrease in the number of AIDS cases has resulted. This good news story means that monitoring only AIDS cases, while very accurate, does not describe the full impact of HIV in a population.

Even reporting of HIV can only give one part of the HIV epidemic picture. HIV reporting in the state of Texas captures only those with a diagnostic test for HIV (WB, PCR, Antigen) since January 1, 1999 and those with a detectable viral load since January 1, 2000. Since HIV itself does not necessarily result in any contact with a medical care provider, the data collected by the local health department most accurately reflects the testing behaviors of the community. In other words the HIV data reflects those who decide to test for some reason, such as:

- They consider themselves at risk for HIV.
- They participate in an outreach/testing event.
- They have some illness that triggers testing.
- They have some other condition or enter a program where testing is routine, such as pregnancy, military recruitment, Job Corps entrance.

What this means is that the reported HIV data, even combined with the reported AIDS data, cannot fully describe the impact of the epidemic in an area. To fully describe what is occurring in any given community, one must use scientifically driven estimates, which include the following components:

- How many people have newly diagnosed AIDS?
- How many people are living with AIDS?
- How many people have been reported with HIV infection?
- What proportion of the people who know they are HIV infected have been reported under the new guidelines?
- What proportion of people with HIV infection have not tested and do not know their status?

Many sources of data can be used to derive estimates of HIV prevalence (all those with HIV disease in an area), including:

- Blinded seroprevalence surveys,
- Survey of child bearing women,
- Experience of states with long term HIV infection reporting,
- Surveys of testing behavior (HITS, SHAS),
- Review of medical records of newly reported HIV infected individuals to determine first HIV positive test date (i.e. how long they have been positive), and
- Information about individuals with HIV that was not reportable under the guidelines.

Using all these types of data, several different models and estimates have been made for the total impact of HIV disease in the Houston area. Though estimates range from 14,000 to 25,000, the general consensus is that the most acceptable estimate of total HIV infected individuals in the area is between 18,000 and 22,000.

IMPACT OF HIV/AIDS BY GEOGRAPHIC AREA

Because we are talking about a 10-county area, it is important to highlight some geographic differences in the HIV epidemic. Foremost, with Houston at its center, Harris County accounts for the overwhelming majority of people living with HIV/AIDS. Of the 11,268 cases reported through December 2001, 95% were living in Harris County. But do not let the relatively small numbers in the other counties lull you into thinking that HIV does not exist outside the big city. Table 25 shows the number of reported living cases in the rest of the area. Please note that in order to maintain confidentiality, some counties have been combined.

Table EPI-25: LIVING HIV INFECTIONS AND AIDS CASES, BY COUNTY – THROUGH 12/31/01

County	AIDS cases	HIV infections	Total
Harris	7,296	3,375	10,671
Fort Bend	183	77	260
Montgomery	111	66	177
Chambers, Liberty, Walker	64	23	87
Austin, Colorado, Waller, and Wharton	51	22	73
Total	7,705	3,563	11,268

CO-FACTORS

This section presents a brief discussion on several co-factors, or conditions related to HIV infection. Co-factors can be important for two reasons: 1) a co-factor can increase the likelihood that a person engages in a behavior that puts them at risk for HIV infection (e.g., substance use), and 2) a co-factor can increase the likelihood of contracting HIV if exposed (e.g., sexually transmitted infections). Again, the discussion is not exhaustive and includes only those co-factors for which significant local data were available.

Sexually Transmitted Infections

HIV is just one of a number of preventable sexually transmitted infections (STIs) that pose a risk for people. Information on these other STIs is important for two reasons: 1) people with other STIs are at increased risk both of becoming infected with HIV and of infecting others, and 2) STIs are an indicator of sexual activity and most are an indicator of unprotected sexual contact, a significant behavioral risk factor in the transmission of HIV. Table 26 shows the number of cases of chlamydia and gonorrhea in 2000 by

county. Please note that in order to maintain confidentiality, the numbers for some counties have been excluded, as have the numbers for syphilis altogether.

Chlamydia, caused by the bacterium *Chlamydia trachomatis*, is one of the most common sexually transmitted infections. The numbers of people with chlamydia infections have increased dramatically, partially due to increased screening in women. At the end of 2000, TDH reported 68,758 cases of chlamydia statewide, 20% of which were in the Houston area. Although the Houston area as a whole had a rate per 100,000 population less than the State rate (291 vs. 338), three of the counties in the Houston area had rates higher than the state average.

Gonorrhea is an infection caused by the bacterium *Neisseria gonorrhoeae*. The national rate of infection with gonorrhea has remained steady for the last three reporting years. At the end of 2000, TDH reported 32,895 cases of gonorrhea statewide, with 20% in the Houston area. The Houston area as a whole had a rate of 124 per 100,000 population, which is less than the state rate of 162 per 100,000. However, the same three counties in the Houston area exceeded the state average.

Comparing the reported chlamydia and gonorrhea cases for the first three quarters of 2001 to the first three quarters of 2000, shows a slight decrease in the numbers of infections reported across the state.

Syphilis is a sexually transmitted infection caused by *Treponema pallidum*. The infection causes a genital ulcerative disease that may contribute to transmission of HIV infection. Syphilis has been the object of a prominent eradication effort nationwide, known as the Syphilis Elimination Program. There were 398 cases of primary and secondary syphilis reported in 2000 statewide, with 22% in the Houston area. The state had 3,303 total cases of syphilis in 2000, with 30% coming from the Houston area. Comparing the first three quarters of 2001 to the first three quarters of 2000, Harris County has shown an increase in primary and secondary syphilis cases, though not in total syphilis (which includes congenital syphilis).

Table EPI 26: REPORTED CASES OF CHLAMYDIA AND GONORRHEA, BY COUNTY – THROUGH 12/31/00

County	Chlamydia	Gonorrhea
Austin	22	--
Chambers	34	--
Colorado	30	--
Fort Bend	519	208
Harris	12,218	5,917
Liberty	117	45
Montgomery	380	155
Walker	228	100
Waller	223	107
Wharton	129	55
Total	13,900	6,614*

*Total includes the cases not listed under the first three counties.

Substance Use

HIV and substance use are most commonly connected through the use of injection drugs. Injection drug users (IDUs) are put at risk through unhygienic injecting practices, the most dangerous of which is the re-use of needles. Users usually draw blood into the needle and syringe to verify the needle is in a vein. If that blood is infected with HIV, subsequent use of the needle or syringe by another user may result in transmission of the virus. But injection drug use contributes to the spread of HIV far beyond the circle of those who inject. Studies of HIV prevalence among patients in drug treatment centers and among childbearing women demonstrate that the heterosexual spread of HIV in women closely parallels the spread of HIV among injection drug users. The highest prevalence rate in both groups has been observed on the East Coast and in the South.³ The two most commonly injected drugs are cocaine and heroin.

Due to the usual limitations inherent in reaching a population as “invisible” as injection drug users, the number of people who inject drugs is difficult to determine. One commonly used source is treatment information provided by the Texas Commission on Alcohol and Drug Abuse (TCADA). According to TCADA, there were 40,439 adult admissions to TCADA-funded treatment facilities in 1999, with almost 9% of these for cocaine use and over 12% for heroin use. Almost 44% of the cocaine users and over 90% of heroin users injected the drug. TCADA also reported 5,338 youth admissions, 6% for cocaine use and just over 2% for heroin use. Among youth, over 8% of the cocaine users and over 62% of the heroin users injected the drug. Admissions from Harris County accounted for 17.5% (7,066) of TCADA adult admissions and 21.2% (1,136) of youth admissions. Over 11% of the adult admissions and 2% of the youth admissions were for injection drug use. Table 27 presents more current TCADA treatment data at the county level; some numbers have been excluded in order to protect confidentiality.

Table EPI-27: TCADA 2001 ADMISSIONS, BY COUNTY

County	Adult Admissions		Youth Admissions		Total
	#	% using needles	#	% using needles	
Austin	13	8%	--	--	13
Chambers	99	5%	42	0%	141
Colorado	15	0%	--	--	15
Fort Bend	57	0%	24	0%	81
Harris	5,058	13%	805	0%	5,863
Liberty	78	8%	--	--	78
Montgomery	205	19%	35	9%	240
Walker	43	12%	10	0%	53
Waller	10	10%	--	--	10
Wharton	30	23%	--	--	30

One important aspect of treatment data is that they are likely to be a very conservative estimate of the number of people actually using drugs. Treatment options are limited and, therefore, demand far outweighs supply. The National Household Survey on Drug

³ Centers for Disease Control and Prevention (CDC). *Trends in the HIV & AIDS Epidemic*. Atlanta, GA: CDC; 1998.

Abuse is an annual nationwide survey among Americans aged 12 and older conducted by the National Institute on Drug Abuse. The latest survey, conducted in 1999, shows that about 14.8 million Americans (or 6.7% of the population) were current users of illicit drugs, meaning they used the drug at least once during the month prior to being interviewed.⁴ About 3.5 million were dependent on illicit drugs. Results of a TCADA survey conducted in Texas in 2000 show that 40% of adults reported they had ever used an illicit drug and over 9% reported using in the past year. In Region 6, which includes the 10 counties and Brazoria, Galveston, and Matagorda Counties, that number increases slightly to over 10%.

Tuberculosis

Tuberculosis (TB) is a bacterial disease that primarily infects the lungs and is transmitted from person to person through the air. After decades of decline, TB is once again emerging as a public health concern in the United States, due largely to the HIV epidemic and growth in the incarcerated population. The link is the weakening of the immune system: people with HIV are more likely to become infected with TB and to progress to TB disease.

Statewide in 2001, there were 1,643 reported cases of TB. From 1995 to 2000 there was a steady decline in reported cases, bottoming out at 1,506. The 2001 figure is an increase of 9% from the previous year, but still slightly less than the number of cases reported in 1999 (1,649). In the 10-county area, Harris County accounted for most (430, or 86%) of the 500 cases reported in 2001. Following the State trend, this is an increase of 9% over the cases reported in 2000, but less than those reported in 1999 (456). Most of the other counties in the area have reported a relatively low number of cases over the past 7 years, ranging from 1 to 5 each year. Fort Bend and Montgomery Counties fare slightly worse, reporting from 6 to 31 and 5 to 19 cases each year, respectively. The 2001 numbers for each county (23 for Fort Bend and 7 for Montgomery) represent small increases over the 2000 numbers (20 and 5, respectively). TDH reports that 10% of the State's TB cases were co-infected with HIV; but in Houston, that percentage rises to 17%. As a consequence of infectious TB cases occurring in people with HIV, there is an increase in the general rates of transmission, creating more problems for treatment of TB disease. Treatment of TB involves administration of five antituberculous medications, two of which are critical for successful treatment. TB strains resistant to these drugs threaten the success of patient treatment and public health programs. While data at the county level were unavailable, TDH estimates that 9.1% of TB cases statewide were resistant to at least 1 of the 5 drugs. The number increases very slightly to 9.3% for people with HIV.

Incarceration

Texas has one of the largest prison systems in the world. The Texas Department of Criminal Justice (TDCJ) operates 114 facilities, including prisons, jails, and substance abuse facilities, over 70% of which are located in East Texas. As of December 31, 1999, there were approximately 151,000 offenders incarcerated in State facilities.

Correctional facilities are reservoirs of illness. High-risk behavioral practices like drug use, unprotected sex, and sexual assault create ideal conditions for the occurrence of

⁴ National Institute on Drug Abuse (NIDA). *National Household Survey on Drug Abuse*. Washington, DC: NIDA; 2000.

sexually transmitted infections, including HIV. While data are limited and vary from region to region, a review of the literature indicates that HIV infection rates are much higher in incarcerated populations than in the general population. In December 1999, the Centers for Disease Control and Prevention (CDC) released a study⁵ of prison inmates from 1994 to 1996 and reported that the prevalence of AIDS was 199/100,000, or 6 times the national rate of 31/100,000. The rate for female inmates was 23 times the national rate for women. In 2000, 714 offenders were diagnosed with HIV and the first half of 2001 indicated similar numbers would be evident by the end of the year. According to TDCJ, based on voluntary testing, during any one month, about 2% of the incarcerated population is HIV positive. In June 2001, 2,450 tested positive.

Over 900 inmates with HIV are living in Houston area facilities. As with much of the information presented here, there are certain caveats to remember. First, the numbers come from *voluntary* testing, which means there are more inmates who are living with HIV but are not getting tested. Second, these numbers reflect only *State-operated* correctional facilities, not Federal, county, or city prisons and jails, or State prisons run by private organizations. One local study, for instance, found that 6% of inmates in the Harris County jail tested positive for HIV, compared to less than 1% for the general population.

Incarcerated populations often are considered isolated from society, but they are an integral part of the larger community, particularly from a public health perspective. Beyond concern for the care and treatment of people who are incarcerated, it is important to remember that most inmates return to the community. Moreover, relapse rates are high. Many of these individuals will return repeatedly to correctional facilities from their community, leading to a substantial circulation of populations at high risk. Each year, 40,000 offenders are released from TDCJ facilities. Over 22% of these are released to Harris County, the highest percentage to any area in the state. In 1999, over 1,000 inmates with HIV were released statewide, with an estimated 35% coming to Harris County. This is supported by the past needs assessment, conducted in 1999, of people with HIV in the Houston area, 30% of whom reported some contact with the prison system.

⁵ Dean-Gaiter H, Fleming P. *AIDS*. 1999;13:2429-2435,2475-2476.

GLOSSARY OF TERMS

AETC: see AIDS Education and Training Center

AIDS: Acquired Immunodeficiency Syndrome. A clinical definition of illnesses caused by HIV: a CD4 count less than or equal to 200 or one of more diagnosed opportunistic infections.

AIDS Education and Training Center (AETC): The AETC was created as part of the Ryan White CARE Act and is administered under Part F. The AETC program is a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers. See the information sheet under Tab 5 for more information.

Allocations: Refers to the distribution of dollar amounts or percentages of funding to established priorities – service categories, geographic areas, populations, or subpopulations. It does NOT involve contracting with or giving money to specific service providers.

API: Asian/Pacific Islander

CDC: see Centers for Disease Control and Prevention

Centers for Disease Control and Prevention (CDC): The CDC is a Federal agency of the Department of Health and Human Services. Their mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. The CDC is the Federal agency responsible for tracking diseases that endanger public health, such as HIV.

Community Planning: Steps taken and methods used by a community to gather information interpret it, and produce a plan for rational decision-making.

Eligible Metropolitan Area (EMA): A designation used by the Ryan White CARE Act to identify an area eligible for funds under Title I. It is aid to metropolitan areas hardest hit by HIV. The Houston EMA consists of the following six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.

EMA: see Eligible Metropolitan Area

Epidemic: A disease that has spread rapidly among a large number of people within a short period of time.

Epidemiological profile: A description of the status, distribution, and impact of an infectious disease or other health-related condition in a specific geographic area.

Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations and the application of this study to the control of health problems.

Ethnicity: A group of people who share the same place of origin, language, race, behaviors, or beliefs.

Health Resources and Services Administration (HRSA): HRSA directs national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is the Federal agency responsible for administering the Ryan White CARE Act.

HIV: Human Immunodeficiency Virus, the virus that damages the immune system and causes AIDS.

HIV Services Delivery Area: A designation used by the Ryan White CARE Act to identify an area eligible for funds under Title II (formula funding to States and territories). There are six HSDAs in the East Texas Planning Area: Beaumont-Port Arthur (covering 3 counties), Galveston (covering 3 counties), Houston (covering 10 counties), Lufkin (covering 12 counties), Texarkana (covering 9 counties), and Tyler (covering 14 counties).

HRSA: see Health Resources and Services Administration

HSDA: see HIV Service Delivery Area

IDU: Injection drug use(r), the term used to refer to the act (and people) of infecting drugs using a needle and syringe.

MSM: Male-to-male sex.

Needs Assessment: A process of collecting information about the needs of people and families at risk of or living with HIV (both those receiving care and those not in care), identifying current resources available to meet those needs, and determining what gaps in care exist.

Part F: Part F of the Ryan White CARE Act administers several programs: 1) Special Projects of National Significance (SPNS), 2) AIDS Education and Training Centers (AETC), and 3) HIV/AIDS Dental Reimbursement Program, which assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to patients with HIV.

Priorities: Refers to the formation of numerical priorities among various categories of services, such as primary care, case management, transportation, and among geographic areas, populations, or subpopulations if needed. The number one priority should reflect the service category or community considered the most critical for the use of funds.

Ryan White CARE Act: On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996 and 2000, the CARE Act is designed to improve the quality and availability of care for individuals and families affected by HIV/AIDS. The CARE Act includes the following major programs: Title I, Title II, Title III, Title IV, and Part F. The CARE Act is now the largest sole source of HIV funding in the Nation.

Sexually Transmitted Infection (STI): Also known as Sexually Transmitted Disease (STD). An infection that is spread through intimate sexual contact. HIV, herpes, syphilis, and gonorrhea are commonly known STIs.

Special Projects of National Significance (SPNS): SPNS is administered by Part F of the Ryan White CARE Act. This program supports the development of innovative models of HIV care and is designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations. See Tab 5 for more information.

SPNS: see Special Projects of National Significance

STD: Sexually Transmitted Disease, see Sexually Transmitted Infection

STI: see Sexually Transmitted Infection

Title I: Under the Ryan White CARE Act, funding is given to eligible metropolitan areas hardest hit by the HIV epidemic. In the East Texas Planning Area, Title I funding is given to the Harris County judge, administered by the Harris County Health Department (HIV Services), and guided by the Houston Area HIV Services Ryan White Planning Council.

Title II: Under the Ryan White CARE Act, funding is given by formula to States and territories to improve the quality, availability, and organization of health care and support services for people and families living with HIV/AIDS. There is an emphasis on rural populations. In Texas, funding is given to the Texas Department of Health. In the East Texas Planning Area, funding is administered by three agencies and guided by the State of Texas Assembly Group East.

Title III: Under the Ryan White CARE Act, funding is given to community-based organizations for outpatient early intervention services. In the East Texas Planning Area, funding is given to two organizations – 1) Harris County Hospital District serving people with HIV in Harris County, and 2) the Houston Regional HIV/AIDS Resource Group, serving 41 counties.

Title IV: Under the Ryan White CARE Act, funding is given to public and non-profit entities to coordinate services to, and improve access to research for, children, youth, women, and families. In the East Texas Planning Area, funding is given to the Houston Regional HIV/AIDS Resource Group, serving the greater Houston area.

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